PROGRESS REVIEW

Family Planning

DEPARTMENT OF HEALTH & HUMAN SERVICES ■ PUBLIC HEALTH SERVICE ■ March 26, 1996

In a review of progress on HEALTHY PEOPLE 2000 objectives for family planning, the Office of Population Affairs, lead agency for this priority area, provided an overview on the status of twelve objectives. Data from the 1995 National Survey of Family Growth (NSFG), expected in 1997, will be used to update nine objectives—5.1, 5.2, 5.3, 5.4, 5.5, 5.8, 5.9, 5.10 and 5.11.

5.1 Adolescent pregnancy is a national concern. This objective is moving away from the year 2000 target of 50 adolescent pregnancies per 1,000, with 74.6 per 1,000 adolescents (aged 15-17) becoming pregnant in 1991.

5.2 Data from the 1990 NSFG telephone reinterview survey indicate that the proportion of live births from unintended pregnancies have increased by 4 percent since 1988. Unintended pregnancies include all pregnancies that are either mistimed or unwanted at the time of conception.

5.3 This objective measures the proportion of married couples who have not been surgically sterilized, have not used contraception and have not become pregnant in the past twelve months.

5.4 Updates from the Youth Risk Behavior Survey (YRBS) indicate that this objective, which seeks to reduce the proportion of adolescents who have engaged in sexual activity, is moving away from the target. Adolescent sexual activity among females has increased from 27 percent at age 15 in 1988 to 38 percent in 1995. Among males of that age, it has increased from 33 percent to 42 percent in the same period.

5.5 Updates from the YRBS indicate that there has been no substantial change in abstinence rates among adolescents.

5.6 YRBS data show that, in 1995, 83 percent of sexually active, unmarried females aged 15-19 used contraception, as did 85 percent of sexually active, unmarried males in that age group. The year 2000 target is to increase to 90 percent the proportion of sexually active, unmarried people aged 15-24 who use contraception.

5.7 This objective addresses the proportion of couples who experience pregnancy due to inconsistent or incorrect use of contraceptives. The original baseline was revised during the mid-decade review using data from the 1988 NSFG and the target was proportionately adjusted.

HIGHLIGHTS

- The prevention of unintended pregnancy, including adolescent pregnancy, is a public health priority. Almost 60 percent of all pregnancies in the United States are unintended. The cost for pregnancy-related medical care for a woman using no contraceptive method is estimated to be $3,000 a year.
- Reducing the burden of unintended pregnancy requires a multi-faceted approach. Goals include delaying the onset of sexual activity among young adolescents, encouraging the use of contraceptives among women at risk, improving male involvement, improving correct and consistent use of effective methods, encouraging dual method use when sexually transmitted disease risk is a concern, and providing wider access to emergency contraception.
- Contraception is the keystone to the prevention of unintended pregnancy. All contraceptive methods are cost effective when compared with the use of no method. It is estimated that publicly funded family planning services assist in averting up to 3.1 million unintended pregnancies each year. An average of $4.40 in health and welfare costs are saved for each public dollar spent on family planning services.
- By helping families avoid unintended pregnancy and achieve optimal spacing of children, and by helping assure access to preconception education and care, early pregnancy diagnosis, and early pre-natal care, family planning services play a critical role in reducing maternal and infant morbidity and mortality.

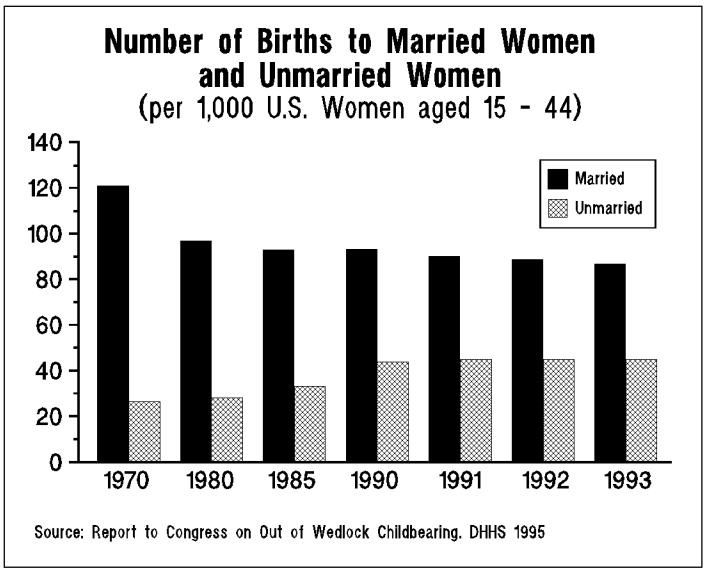
5.8 Improving family communication about human sexuality and increasing access to human sexuality education continue to be important strategies in adolescent pregnancy prevention efforts. Data from the National Health Interview Survey indicate that 89 percent of children aged 10-17 had received information on human sexuality from parents, schools, or churches; 73 percent received the information from parents. Supplemental data from the School Health Program and Policies Survey (SHPPS) indicate that 80 percent of junior and senior high schools include human sexuality education in a required course.

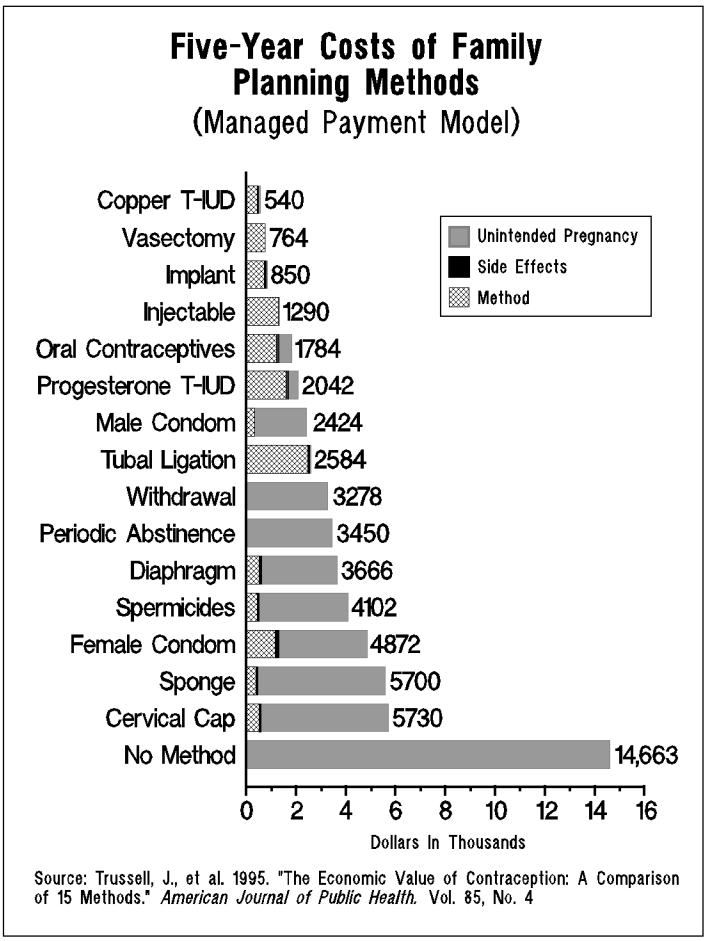
5.9 This objective was revised in the midcourse review to address the broader issue of ensuring the provision of accurate information on all options during pregnancy counseling.

5.10 Baseline data on the proportion of primary care physicians who provide age-appropriate preconception care and counseling show that, in 1992, the percentage of clinicians who routinely inquired about family planning ranged from 18 percent of pediatricians to 53 percent of nurse practitioners.

5.11 This objective seeks to increase the number of public health providers who provide, either on-site or through referral, prevention services for the sexually transmitted diseases (STDs), including HIV infection, to individuals and their partners. The baseline was drawn from a one-time survey of family planning providers. The 1995 NSFG will provide an update for the objective.

5.12 This new objective, added during the midcourse review, focuses on increasing the proportion of females 15-44 at risk of unintended pregnancy who use contraception. Data from the 1988 NSFG indicate progress toward the target.





FOLLOW-UP

- Improve communication. The public, policy-makers, and health providers need information about health benefits and cost savings of family planning. Clinical services and health education in family planning need to adopt communication industry expertise, and consider the applicability of education and social marketing approaches used in other countries in order to get family planning messages widely disseminated.

- Widen partnerships. Changing patterns of health care delivery mean that family planning services will be provided by an expanded circle of clinicians, who need information to improve counseling and service delivery. Renewed outreach efforts are also needed for underserved populations such as adolescents, homeless people, and substance users. Partnership with other youth-serving, social service, and educational organizations is an important step in expanding primary prevention and educational efforts.

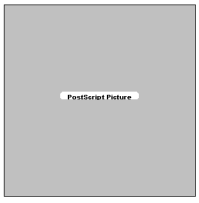
- Involve male partners. The role of males in family planning is given too little emphasis by many counsellors. Male partners of sexually active women need to be advised to seek advice about appropriate contraceptive practices and encouraged to emulate models of mature and responsible manhood and fatherhood. It is incumbent on primary care providers to carry out appropriate counselling and referral services.

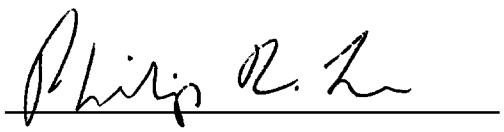
- Encourage research and development. Private sector innovation and marketing capabilities can help achieve family planning goals. Public policies, including regulatory processes, should encourage private sector collaboration, e.g., "fast track" FDA approval processes. Products that reduce transmission of sexually transmitted infection and products suitable for emergency contraceptive use deserve high priority.

- Encourage innovation in evaluation and data collection. New evaluation methodologies, especially those suitable for local use as part of ongoing outcome assessment, are needed, as well as timely, accurate measures of fertility. Dissemination of data and analysis, through *Morbidity and Mortality Weekly Report* and other media, can help States and local communities assess program successes.

PARTICIPANTS

Office of Population Affairs (Lead Agency)
Agency for Health Care Policy and Research
Alan Guttmacher Institute
American College of Obstetricians and Gynecologists
Centers for Disease Control and Prevention
Child Trends, Inc.
Family Health International
Family Planning Council of Southeastern Pennsylvania
Health Resources and Services Administration
Indian Health Service
National Institutes of Health
Office of the Assistant Secretary for Planning and Evaluation
Office of Disease Prevention and Health Promotion
Office of Minority Health
Office of Public Health and Science
Office of the Surgeon General
Princeton University





Philip R. Lee, M.D.